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SUMMARY:

ACSI/CCCD SUSTAINABILITY ASSESMENTS IN GUINEA, LESOTHO, NIGERIA & RWANDA 1992-1993

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LIST OF ACRONYMS

ACSI	Africa Child Survival Initiative
ARI	acute respiratory infection
CCCD	Combatting Communicable Childhood Diseases
CDC	Centers for Disease Control
CDD	control of diarrheal disease
CDIE	Center for Development Information and Evaluation
EPI	expanded programme in immunization
HE	health education
HIS	health information system
KAP	knowledge-attitude-practice
LDCs	less(er) developed countries
M&E	monitoring and evaluation
MOH	Ministry of Health
NGO	non-governmental organization
OR	operations research
ORS	oral rehydration salts/solution
PHC	primary health care
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USPHS	United States Public Health Service
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

1. The ACSI-CCCD Projects in Guinea, Lesotho, Nigeria, and Rwanda and the government primary health care programs that they supported were assessed with respect to their sustainability in late 1992 and early 1993. In three countries, the ACSI-CCCD Projects had ended approximately two to four years earlier, while the Nigeria ACSI-CCCD Project was still ongoing.

2. The overall objective of the four sustainability assessments and this summary is to provide the USAID Africa Bureau with operational guidance, insights, and information on how to design, implement, and phase out projects to ensure maximum sustainability of achievements and activities.

3. The conceptual basis for the assessment came from the ACSI-CCCD Sustainability Strategy and an earlier six-country sustainability research study funded by CDIE/USAID. The four assessments used the definition of sustainability (continuation of project activities and benefits for three years after cessation of project funding) and the project attributes (called sustainability criteria) found to be associated with increased sustainability by the CDIE study.

Findings on Sustainability of the Projects

4. In spite of deteriorating economic conditions and disruptive political conditions in most of the countries, the assessments found that the four ACSI-CCCD Projects were sustained to a surprisingly high level. Most project components were sustaining, some with higher quality. The sustainability in Guinea and Rwanda was particularly encouraging, while it was mixed in Lesotho. The prognosis in Nigeria, based on the sustainability criteria, was also encouraging. This result differs from the six-country study, which found very low sustainability in Africa.

5. The direct service components of the projects, namely EPI, CDD, malaria, and, in Lesotho, ARI, were sustained to a greater degree than the support components (training, health education, information systems, operations research, and, in Nigeria, monitoring and evaluation).

6. Among direct service components, EPI was easily the winner in terms of sustainability.

7. Among the support components, training had the highest sustainability. The sustainability of most other support components was relatively quite low, except in Nigeria, where HIS and operations research had high prognosis.

8. There was a high degree of consistency across countries with respect to sustainability of components, except HIS and operations research in Nigeria.

9. It is unclear from the assessments why there were such clear differences in sustainability among project components. One clue is that perceived effectiveness (one of the criteria) was consistently higher in EPI than in most other components, especially CDD. Several hypotheses are suggested that might explain the patterns: 1) higher level of other donor support for sustaining components, 2) higher sustainability in more mature components with more time to build experience in the country, and 3) some components are inherently more effective than others.

10. The assessments found that economic and political conditions beyond the control of the project had major influences on sustainability. This result supports the CDIE study, which found that among all contextual factors (conditions outside the control of the project) studied, political and economic had the most influence on sustainability.

11. The assessments made numerous practical recommendations for increasing the effectiveness and sustainability of the particular program they assessed and USAID-funded health projects in general. They included recommendations related to training, health education, decentralization, financing, future USAID projects, and additional studies. These recommendations are summarized in Section II. F.

Methodological Findings

12. The ACSI-CCCD Sustainability Strategy was confirmed for direct service components of health projects. The five criteria and their indicators appear to predict the degree to which projects such as EPI, CDD, and malaria sustained. This conclusion is based on the careful analysis done by the Lesotho assessment, which compared predicted sustainability to actual continuation of CCCD Project activities 20 months after the project funding ceased, and on similar but less formal analysis by the Guinea and Rwanda assessments.

13. Sustainability is multi-dimensional, in the sense that several factors are major contributors to the continuation of project activities and benefits. The five sustainability criteria (perceived effectiveness, integration, financing, training, and respectful negotiations) are among the required factors. One-dimensional views of sustainability are not supported by the evidence.

14. The Lesotho methodology, which carefully distinguished between benefits and activities that actually sustained and the prediction of sustainability derived from the sustainability criteria and indicators, is appropriate for future assessments. Additional work may be needed to systematize methods for defining and measuring benefits.

15. The Nigeria assessment carefully explored the availability of data which was recommended by the CCCD Sustainability Strategy for performing a sustainability assessment. The results were positive; data of adequate quality were available. The experience of the other assessments supported this finding.

16. The assessments recommended two additional sustainability criteria. Guinea, Nigeria, and Rwanda added ownership as a sixth criterion. Although not tested empirically, the Nigeria assessment makes a strong case for the importance of ownership in Nigeria. The Lesotho report recommends adding perceived affordability to the list of sustainability criteria, as a parallel to perceived effectiveness, and makes a strong case for this recommendation. It may be worthwhile to analyze these recommendations in light of the data in the CDIE six-country study.

17. Although the assessment methodology works well for direct services components such as EPI and CDD, it is not so useful for assessing the sustainability of support components such as training and HIS. New criteria and indicators for support components should be developed.

18. One strategy for maintaining projects is to acquire other donor funding. It is one of the ways that countries have sustained the CCCD activities. It is not clear how this should be counted in defining sustainability -- the CDIE six-country study is silent on the matter. The Lesotho report makes a strong case that it should count as a legitimate method of sustaining projects. Sequential funding by several donors may be a desirable medium-term strategy for building effectiveness and perceived effectiveness in poor African countries.

19. The Lesotho report makes a strong case that sustainability is a confused and possibly misleading concept that should be replaced by a cost-benefit framework. Further, it masks unstated interests in changing fundamental aspects of the public health sector in developing countries (such as priorities and intellectual styles) that should be stated explicitly and negotiated.

20. The CDIE data should be re-analyzed along with the data from the four assessments to answer several questions, including the appropriateness of the affordability and ownership criteria, good sustainability strategies for support components, insight into other donor support as a viable financial strategy, and methods for weighing or prioritizing criteria and indicators. Decisions to modify the existing set of criteria, for example by adding affordability or ownership, need to be considered in light of their marginal contribution to predicting sustainability given the other criteria. Analysis of criteria weighing or prioritizing should consider the possibility of different weighing schemes for different types of components and projects, and for countries under different conditions, such as might be determined by contextual factors.

Lessons Learned

21. The four assessments arrived at many lessons, which are summarized in Section IV.

I. INTRODUCTION

Background

Sustainability assessments of four CCCD country projects (Guinea, Lesotho, Nigeria, and Rwanda) were undertaken in late 1992 and early 1993 with funding from the USAID Africa Bureau[1]. This is a summary of the findings of the four assessments. It is based on the draft and final reports for Guinea, Nigeria, and Rwanda and the draft final report for Lesotho[2]. This summary also benefitted from discussion with and written commentary from assessment team members, discussion with CCCD staff, and an excellent literature review by CDIE.

The sustainability of USAID projects has been a concern for a long time[3], but only recently has the issue been addressed with much degree of scientific rigor. A study[4] of 49 USAID-funded health projects in six countries investigated the relationship between project sustainability and numerous factors hypothesized to be related to sustainability. Projects were defined to be sustained if at least one major activity of the project or its benefits continued for at least three years after USAID funding to the project ceased. The study found that five project attributes (over which the project had substantial control) and four contextual factors (over which the project had little control) were highly correlated with projects that sustained. The five project attributes and five contextual factors are listed in Table 1 and described in more detail in Appendix A.

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[1] For over a decade, the U.S. Agency for International Development (USAID) funded the Centers for Disease Control, U.S.P.H.S. to carry out multi-year child health projects in several African countries. Originally known as Combatting Childhood Communicable Diseases (CCCD), and later as Africa Child Survival Initiative/Combatting Childhood Communicable Diseases (ACSI/CCCD), they are referred to as "CCCD Projects" in this paper.

[2] (1) Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases (CCCD) Project -- Guinea, 1993. May 4, 1993. (2) Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases (CCCD) Project -- Lesotho, 1993 (Draft). May 21, 1993. (3) Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases Project -- Nigeria, 1992. (4) Sustainability Assessment of the Africa Child Survival Initiative (ACSI) Combatting Childhood Communicable Diseases (CCCD) Project -- Rwanda. May 7, 1993. All four reports were prepared by Atlantic Resources Corporation, Reston, VA.

[3] For example, see Paddock W & Paddock E. We Don't Know How. Ames: Iowa State University Press, 1973.

[4] (1) CDIE/USAID. Factors influencing the sustainability of U.S. foreign assistance programs in health, 1942-1989: A six-country synthesis -- Draft. December, 1990; and (2) Bossert T. "Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa." Soc Sci and Med, vol 30, no 9, pp 1015-1023. 1990.

Table 1: Factors Thought to Affect Sustainability

Project Factors	Contextual Factors
1. Perceived Effectiveness	1. Economic Factors
2. Integration and Institution Strengthening	2. Political Factors
3. Local Financing, Community Participation, and Private Sector	3. Resource Factors
4. Strong Staff Training	4. Socio-Cultural Factors
	5. Environment Factors
5. Constituency Building Through Respectful Negotiation	6. Strength of Implementing Institution
	7. National Commitment
6. Ownership	

NOTES: Project factors 1-5 were identified in the CDIE research study, included in the CCCD Sustainability Strategy, and used by all four CCCD assessments. Project factor 6 was not in the CDIE study nor Sustainability Strategy, but was used by three CCCD assessments. Contextual factors 1 and 2 were identified by the CDIE study and used by all four CCCD assessments. Contextual factors 3-5 were used by three CCCD assessments, but not identified in the CDIE study. Contextual factors 6 and 7 were identified in the CDIE study but not used by any CCCD assessments.

These results were used by the Africa Bureau of USAID and the CCCD Project to develop a Sustainability Strategy,[5] which has the dual objectives of helping design and manage projects in ways that will make them more sustainable, and providing a framework for assessing the sustainability of CCCD Projects.[6] The strategy rests on the assumption that projects that have the five attributes are more likely to sustain than projects that do not have

[5] University Research Corporation. "Sustainability Strategy." Africa Child Survival Initiative -- Combatting Childhood Communicable Diseases (ACSI-CCCD), USAID. December, 1990.

[6] This summary differentiates between the word "sustained," referring to activities and benefits of projects which in fact continue after project funding ceases, and "sustainability," referring to the extent which projects have attributes that contribute to their being sustained.

these attributes. Thus, the five attributes are established as objectives for projects, because their achievement is likely to increase project sustainability. The five attributes are referred to as "sustainability criteria" or just "criteria" in the strategy and in this paper. The strategy identifies activities that are likely to contribute to the achievement of the objectives, and recommends several indicators for each objective (thus providing an operational definition that can be used in measurement). The Sustainability Strategy does not address the contextual factors that were found to be related to sustainability.

The four CCCD country sustainability assessments were undertaken within the conceptual framework of the CCCD Sustainability Strategy. They all adopted the five sustainability criteria and their associated activities and indicators from the strategy. Three assessments added a new, sixth criteria, ownership. In addition, the assessments looked at the role of five contextual factors, two of which (economic and political) were identified as important in the earlier research.

None of the four CCCD Project objectives originally included sustainability. Rather, sustainability emerged as a desirable goal during the 1980s. It was officially documented in the 1990 CCCD Sustainability Strategy.

B. CCCD Projects

The four CCCD country projects all placed resident advisors who provided technical assistance to government child health programs for several years. In most cases the CCCD Projects were integrated with and worked to strengthen existing Ministry of Health (MOH) primary health care programs. The exception was Guinea, where the CCCD Project collaborated with but not through the MOH primary health care program. Thus, the sustainability assessments faced the issue of whether to address the sustainability of the CCCD activities or of the main program[7] the CCCD Project was trying to strengthen. All four chose the main program. In fact, the Lesotho assessment concluded that "it is not feasible to separate a sustainability evaluation of a CCCD Project from a sustainability evaluation of the main program."

The CCCD Projects provided support to the same types of programs and activities in each of the four countries, namely immunization (EPI), control of diarrheal disease (CDD), malaria, health education (HE), staff training, health information systems (HIS), and operations research (OR). The exceptions were Lesotho, where acute respiratory infection (ARI) was substituted for malaria, and Nigeria, which added monitoring and evaluation (M&E). Note that the list contains both direct service programs focused on particular

[7] This paper refers to the Ministry of Health program(s) that CCCD worked to strengthen in each country as the "main program," to distinguish it from the "CCCD Project."

diseases (EPI, CDD, malaria, ARI) and support activities (training, HE,[8] HIS, OR, M&E). The support activities were among those recommended in the CCCD sustainability strategy. (This paper refers to these programs and support activities as "components.")

The Guinea, Lesotho, and Rwanda CCCD Project funding had ceased prior to the assessment, while the Nigeria CCCD funding was still ongoing. The time since the cessation of USAID funding for each of the projects is noted below.

Country	Time Between End of USAID Funding and Assessment
Nigeria	ongoing
Guinea	16 months
Lesotho	20 months
Rwanda	4+ years

C. Assessment Objectives and Methodologies

The scope of work for each country project assessment includes the following purposes:

1. Assess the extent to which project activities and achievements have been sustained;

2. Address whether the project met the five objectives of the Sustainability Strategy and how they contributed to project sustainability;

3. Address whether other project attributes are necessary to achieve project sustainability;

4. Discuss whether and how contextual factors have influenced project sustainability;

5. Address whether sustainability of donor projects in the country is a realistic goal, and

6. Document lessons learned that have relevance to other projects or countries.

The four sustainability assessments were all undertaken within the framework of the CCCD Sustainability Strategy. As a result, they all adopted the same definition of sustainability, namely, "the persistence of project activities or benefits for three years following the cessation of USAID funding for the project," and they all included the five criteria adopted by the strategy as sustainability objectives.

[8] Health education (HE) might be considered a direct service activity as well as a support activity because it provides services directly to the general population, but it is grouped with support activities in this paper to be consistent with the CCCD Projects and sustainability assessments.

However, the four assessments also differed in some important ways. Unlike the other three countries, the Nigeria CCCD Project was still ongoing at the time of the assessment and thus could not address the extent to which project activities and benefits were actually sustained. The Guinea, Nigeria, and Rwanda assessments introduced and used a sixth sustainability criteria, ownership, which was felt to be highly related to sustainability. Lesotho undertook a more careful measurement than did the other three assessments of actual continuation of project activities and benefits as distinct from predicted sustainability based on the five (six including ownership) criteria. The four assessments used different methods for scoring and combining the indicators to obtain overall assessments of the sustainability of the different program components.[9]

The findings from the four assessments can be conveniently grouped in two categories -- findings related to the sustainability of the CCCD Projects and their components, and findings related to the methodology that was used to define and predict sustainability. The first category deals with questions such as which components are most sustainable and why, and suggestions for improving the sustainability of particular activities in particular countries. The second category (methodology) deals with questions such as the availability of data, the adequacy of the five criteria to predict sustainability, and the appropriateness of the definition of sustainability adopted by the sustainability strategy.

[9] In the Nigeria assessment, each study team member assigned a probability score to each component (ranging from 0 for "no possibility to sustain" to 5 for "high probability of high quality program sustaining"), and an influence value to each attribute of each component (ranging from 1 for weak influence to 3 for strong influence). Overall component and attribute sustainability "scores" were obtained by averaging the individual scores. In the Guinea and Rwanda assessments, the study team assigned a consensus sustainability score to each component after assigning favorable or unfavorable status to a long list of indicators contributing to the six attributes, where 0 = not sustainable, 1 = permanent but lower quality, 2 = permanent with maintenance of quality, and 3 = permanent and higher quality. The Lesotho assessment used written rather than quantitative descriptions of the sustainability of components and their attributes.

II. FINDINGS ABOUT THE SUSTAINABILITY OF THE PROJECTS

A. Sustainability by Country -- The Overall Judgment

In spite of many difficulties and the fact that sustainability was not an original objective, the CCCD Projects were judged to have sustained, or in Nigeria's case likely to sustain, rather well in all four countries. Although there were some components that did not sustain in some countries, the overall judgment was very favorable. The one possible exception to this very positive result may be Lesotho, with a mixed result -- some components sustaining and others not. All countries had components that not only sustained but improved quality of service since the termination of USAID funding. Some quotations from the assessment reports summarize this judgment:

> "With the exception of the OR component..., there is no question that project activities are continuing and that CCCD services continue to be provided nearly five years after the PACD [project activity completion date] in Rwanda." (Rwanda Report, p. vii)

> "Thanks to the national PHC program..., the three CCCD interventions -- vaccinations, diarrheal disease control, and malarial treatment and/or chemoprophylaxis -- are not only being continued but are being expanded annually to increase the target population's access to services." (Guinea Report, p. vii)

> "Major project achievements [include] increased immunization coverage rates, expanded (ORT) services, and the design and implementation of an (ARI) control program." (Lesotho Draft Report, p. vii) "EPI...activities have been largely sustained. ...ORT track record is not good. ...ARI continues to operate in a satisfactory way. ...HIS capacity appears to be still in place but mostly it is not being put to good use." (Lesotho Draft Report, p. 6-2)

> "HIS, EPI, and Training components are likely to be sustained. Malaria and (OR) have greater than modest probability of being sustained, and (HE) and CDD have a modest probability of being sustained...the M&E component is in jeopardy. ...each [component] would have been given a much higher probability of being sustained...[if] the definition of sustainability permitted program costs to be covered by other donors."[10] (Nigeria Report, p. 25)

[10] This statement may reflect a misrepresentation of the definition of sustainability. The original CDIE study that provided the empirical basis for the Sustainability Strategy was silent on the issue of funding by other donors.

This achievement is remarkable in light of the generally negative economic and political conditions (contextual factors) which confront the four countries. Lesotho is experiencing economic decline and severe brain drain; Rwanda is in the midst of a civil war; Nigeria is in the midst of economic decline and disruptive political reform. Only Guinea has a somewhat positive context due to strong government support for the PHC program.

African development projects have not fared so well in the past, certainly with respect to sustainability. For example, the CDIE six-country sustainability study found the average sustainability of African projects to be much lower than the sustainability of projects in Asia (Thailand) or Central America. The positive findings of the present four assessments stand in stark contrast to previous reports, and for that reason are especially interesting.

B. Sustainability of Individual Project Components

A clear pattern emerges from the four assessments with respect to the sustainability of the different components. The key findings with respect to the sustainability of components are listed below and are also seen in Table 2.

1. EPI is the easy winner among service programs with respect to sustainability. In Guinea and Rwanda, it was judged as "permanent with improved quality," the only component in this category. In Nigeria, EPI was the only service program "likely to sustain." The Lesotho report says the "majority of (EPI) benefits were being sustained."

2. CDD, malaria, and, in Lesotho, ARI appear to have been moderately sustained (in Nigeria, with moderate sustainability), with some exceptions. (CDD is "faltering" in Lesotho; malaria is high in Nigeria but low in Rwanda; ARI is operating "satisfactorily" in Lesotho.)

3. Staff training is the clear winner with respect to sustainability among the support components. In Nigeria, it was judged "likely to sustain" (along with HIS). In Rwanda, training was the only support component that received the highest rating -- "permanent with improved quality." In Guinea, it was the highest ranked support component -- "permanent with maintenance of quality." In Lesotho, the comments on the degree to which training was sustained were mixed.

4. The other support activities (HE, HIS, OR, M&E in Nigeria) did not fare so well. They were judged not sustainable or sustained with low quality everywhere except Nigeria, where the opposite conclusion was reached for HIS and OR, which were judged to have more than a modest probability of sustainability.

5. The above findings were very consistent across the four countries, with the one extreme exception of HIS and OR in Nigeria.

TABLE 2: Sustainability of CCCD Components by Country				
Component	**Nigeria[1]**	**Guinea[2]**	**Rwanda[2]**	**Lesotho[3]**
EPI	2.8	3	3	Most benefits sustained
CDD	1.9	2	2	Faltering program
Malaria	2.6	2	1	--
ARI	--	--	--	Satisfactory
HE	2.0	1	2	Gaps
Training	2.9	2	3	Mixed
HIS	3.4	1	1	Not sustained
OR	2.5	0	0	Not sustained
M&E	1.3	--	--	--

Notes: (1) In Nigeria, scale ranges from 0 (no chance of sustainability) to 5 (high chance of high quality sustained program), and reflects an average assessment based entirely on project attributes. (2) In Guinea and Rwanda, scale ranges from 0 (not sustained) to 3 (sustained with improved quality), and appears to be based at least in part on project attributes. (3) In Lesotho, comments reflect actual activities and benefits observed.

C. Why Some Components Are More Sustainable than Others

Why was EPI more sustained and sustainable than other direct service programs, and training more sustained and sustainable than other support programs? Why were HIS and OR sustainable in Nigeria and nowhere else? In other words, can the results in the previous section be explained?

One way to answer this question is in terms of the sustainability criteria. Were certain criteria systematically more present in the more sustainable and sustained components? Some of the data to answer the question is found in what the country assessment reports call their Sustainability Tables. In these tables, the criteria indicators are scored positive or negative for each component in the country program. They provide a convenient summary. (The four sustainability tables are attached as Appendix B.)

The sustainability tables show that perceived effectiveness, an attribute that contributed positively to most components, and especially to EPI, was generally negative for CDD, and thus appears to be a major reason for the poor sustainability of CDD. Note that "perceived effectiveness" refers to projects that are both effective and perceived to be effective.

This is only a partial answer. Why was the EPI component more effective and perceived as more effective than the CDD component? The answer to this question is not found in the assessments. However, some hypotheses can be suggested. One hypothesis is that the EPI components have a longer history in these countries than CDD components and that more progress tends to occur with more time. Another hypothesis is that EPI, as currently practiced, is inherently more effective than CDD, as currently practiced. A third hypothesis is that EPI receives more financial support from outside donors (especially WHO and UNICEF) than CDD, and CDD in turn receives more than malaria and ARI. Although this third hypothesis is probably part of the reason EPI was so well sustained, it is not known whether or not EPI would have sustained better than other components even if the advantage of other donor support had not been available. Thus, the correct answer may be a combination of the three hypotheses suggested here.

D. Patterns in Project Factors

This section addresses the question whether the five criteria of sustainability were uniformly positive or negative across countries and components. Are certain criteria a problem everywhere? Are there clear patterns in the data? Unfortunately, the data to answer the questions are not so easily obtainable from the assessment reports. Nevertheless, some general observations are possible.

1. Perceived effectiveness, respectful negotiations, integration, and ownership were rated positively more often than negatively for most components in Guinea, Nigeria, and Rwanda, and thus contributed to the sustainability of the CCCD Project in these countries.

2. Financing and, to a lesser extent, training were generally rated negatively in Guinea, Nigeria, and Rwanda, and thus tended to decrease the sustainability of the CCCD Projects in these countries. In Lesotho, training was judged to have had a positive influence, while the influence of financing was confounded by the overwhelming effect of continuing multi-donor support in the health sector.

E. Patterns in Contextual Factors

The scientific basis for the five contextual factors used in the CCCD assessments is less clear than for the project factors. Two of the contextual factors used in the assessments, economic and political, are clearly identified in the CDIE six-country study as important determinants of sustainability. The other three contextual factors used in the assessments are

not identified in the CDIE study *per se*. However, it appears that the other two contextual factors identified as important by the CDIE study, strong implementing institution and national commitment to project goals, were probably incorporated into the political factor by the CCCD assessments.

The CDIE study concluded that the economic and political factors were the most important of all contextual factors. This finding, and the likelihood that the assessments expanded the definition of the political factor to include other important factors, suggests that economics and politics should have emerged as the most important contextual factors in the CCCD assessments. In fact, this is exactly what happened. Nigeria judged that the economic and political factors were easily the most important among the contextual factors; Guinea and Rwanda both judged the political factor to have the greatest effect on sustainability, in Rwanda a negative effect due to the hostilities and in Guinea a positive effect due to the strong support of the government; and Lesotho judged economics to be the most important factor, although the changing political situation lurks behind some of the economic uncertainties.

It is worth noting that in all cases but one, the economic and political conditions acted to hinder rather than enhance sustainability of the CCCD Projects. The exception was Guinea, where strong government support for the primary health care program and a slightly improving economic situation helped to maintain and improve the CCCD activities after USAID funding ceased. The assessments note that the structural readjustment programs that are ongoing in the countries seem to be contributing to the negative short-term conditions for public health.

F. Recommendations from Assessments

The country-specific recommendations made by the four assessments can be grouped into categories. In some cases all the recommendations in a category come from one assessment, while other categories contain similar recommendations from several country assessments. Recommendations made by the assessments are paraphrased below. (The source of each recommendation is denoted by the letter in parenthesis following the recommendation.)

Future USAID Projects. The Nigeria assessment makes two recommendations with respect to restructuring USAID projects.

1. Define lines of authority and responsibility between USAID missions and PASA partners before new projects start. (G)

2. Include sustainability objectives and indicators in the design of future projects. (N)

10

3. During project design, negotiate the phase-in of local financial support and the phase-out of donor support for project operating expenses. (N)

Training. Several assessments made recommendations for improving the sustainability of the training component. In fact, there are more recommendations about training than any other type.

4. National training policy in Guinea should include needs assessment and continuing education for all health personnel. (G)

5. The PHC program in Lesotho should continuously review and update training materials. (L)

6. The ARI program in Lesotho should give more priority to in-service training at all levels, and to supervision of first-level health workers. (L)

7. As the ARI program in Lesotho expands, pre-service should be a priority. To this end, provide technical assistance in nursing curriculum development. (L)

8. Provide technical assistance to the Lesotho ARI program and program manager on teaching methodology, supervisory training, and on the essential core of the training component. (L)

9. The ARI training materials used in Lesotho are of sufficient quality to use as prototypes in other countries. (L)

10. Continue to review and revise CDD training in Rwanda. (R)

11. Improve the coordination of child survival programs in Rwanda with respect to training. (R)

12. Assess current training needs in Rwanda. (R)

13. Strengthen and expand the national level training program in Nigeria. (N)

Decentralize. The Guinea and Rwanda assessments recommend decentralizing to increase the chances of sustainability.

14. Accelerate the decentralization of management of the PHC program in Guinea. (G)

15. Decentralize the HIS component in Rwanda to the regional and peripheral levels. (R)

16. Decentralize training in Rwanda to the health centers. (R)

Financial Matters. Guinea and Rwanda also recommend seeking other sources of funding.

17. Consider PL480 funds to support the Guinea PHC program.(G)

18. The Government of Guinea needs to find other ways to pay for vaccines, given plans by UNICEF to phase out support. (G)

19. Immediately begin seeking other funding and sources of supplies to maintain the Rwanda health program when UNICEF support diminishes. (R)

20. Monitor the effects of inflation on balances in PHC cost recovery funds and plan expenditures accordingly. (G)

Health Education. The Guinea and Lesotho assessments recommend more attention on health education.

21. The Government of Guinea should plan, develop, and integrate health education into the national PHC program. (G)

22. The government should develop a long-term health education plan. (L)

23. The government should support the Guinea Health Education Unit with recognition and health educators. (G)

24. Promote health education in the primary schools, including technical assistance and teacher in-service training on basic facts of ARI, EPI, and CDD. (L)

Sustainability Assessment Methodology.

25. Current sustainability criteria and indicators are appropriate (with some revisions) for studying sustainability of direct service components of CCCD Projects, but separate criteria and indicators are needed for support components. (G)

26. Modify the wording of indicators A and B under the financing criterion (see Sustainability Tables, Appendix B), and eliminate indicator E under the Ownership criterion. (G)

More studies. The Guinea and Rwanda assessments recommend additional studies, followed by action.

27. Undertake a study of the impact of previous health education activities in Guinea. (G)

28. Undertake an in-depth sustainability assessment of the Guinea PHC program. (G)

29. Undertake a KAP study of anti-malarial drug usage in Guinea, including both consumers and providers. (G)

30. Analyze the child survival financial situation and establish better management tools. (R)

31. Study how best to distribute health costs in Rwanda, including indigents. (R)

Drugs. Various recommendations were made about improving the operation of drug programs in the countries. Note additional recommendation 29.

32. Ensure greater availability of anti-malaria medicines in Rwanda. (R)

33. The ORS inventory left over from the Guinea CCCD Project should be given to the Essential Drug System of the PHC program so that it can be distributed. (G)

34. A national policy on second-line anti-malarial drugs should be established in Guinea, in light of the threat of chloroquine resistant malaria. (G)

Miscellaneous Recommendations.

35. Upgrade the CDD program to the same level as EPI in Rwanda. (R)

36. Develop more management and financial management capacity at the local level in Nigeria. (N)

37. Increase reliance on local technical expertise in Nigeria. (N)

38. The Lesotho MOH should work to increase use of program data by PHC managers at all levels. (L)

39. Strengthen the organization (OSPR) that manages support components in Guinea by clarifying its mandate and providing more resources. (G)

40. The Government of Guinea and the various donors, including USAID, should share their administrative procedures with each other, and should learn each other's administrative procedures. (G)

41. The phase-out of projects should be carefully coordinated with the government and all major donor organizations well before the end of the project. (G)

III. FINDINGS ABOUT METHODOLOGY

A. Testing the CCCD Sustainability Strategy

One of the four country studies, Lesotho, collected data which it used to analyze the soundness of the Sustainability Strategy and the five criteria. To accomplish this, the Lesotho assessment undertook the following steps for each of the seven project components.

1. Determine the activities and benefits that were attained by the project component by the time that USAID funding for the project ceased.

2. Determine the extent to which these activities and benefits were sustained at the time of the assessment, 20 months following the termination of USAID funding, using direct observation.

3. Characterize the project component in terms of the five sustainability criteria and their associated indicators.

4. Analyze the extent to which the criteria predict the actual sustainability of activities and benefits found in step 2.

It is important that the measurement of actual sustainability was totally independent of the criteria used to predict sustainability. Otherwise the predictions would have been self-fulfilling. The measurements and analysis were done for the main MOH program and not just the CCCD Project.

The results are modestly encouraging, in the sense that there is a rough correlation between predicted and actual sustainability among the seven components. Thus, training and EPI were predicted to be the most sustainable components, and, in fact, they were along with ARI. However, training was predicted to be slightly more sustainable than EPI when, in fact, the reverse was the case with respect to the actual observations. Similarly, OR was predicted to be the least sustainable component along with HE, and while OR was observed to be the least sustainable, HE was observed to be in the middle of the pack. In brief, the Lesotho assessment is supportive of the previous findings and the Sustainability Strategy.

The other three country assessments did not undertake such a test. The CCCD Project in Nigeria is still ongoing and therefore was not eligible for such an analysis. The assessments in Guinea and Rwanda, although eligible, appear to have judged the sustainability of each component at least in part by the extent to which the component incorporated the sustainability criteria, and thus do not appear to provide an independent test of the sustainability strategy. Nevertheless, the overall team judgments in Guinea and Rwanda appear to correlate roughly with component sustainability as predicted by the criteria indicators, and so, if anything, tend to support the strategy. This observation is further

supported by evidence in the Sustainability Tables for Guinea and Rwanda showing that the support components have been well to moderately sustained. (See Section III.B. for further discussion of this point.)

B. Problems Assessing the Sustainability of Support Components

The assessment team members expressed confusion and a lack of confidence in the applicability of the sustainability criteria and indicators to the support components. This is in contrast to their general support for the applicability of the criteria (with noted modifications) to direct service components. The primary problem seems to be that some of the support components are used as indicators. Thus, they indicate themselves. For example, the existence of HIS and OR are indicators of perceived effectiveness, health education policy is an indicator of the training criterion, and training is a criterion unto itself. Therefore, it is recommended the sustainability strategy be redesigned for the support components. Data from the original six-country study should be referenced in the re-design.

The dual role of the support components as both indicators and components can be used to an advantage in our interpretation of the Guinea and Rwanda assessments. The role provides recorded evidence whether or not these support components were, in fact, sustained at the time of the assessment. It is objective data for testing the quality of the Sustainability Strategy with respect to support components. Specifically, we consider the following indicators: indicators 1-B (HIS implemented) and 1-D (data used to make decisions) indicate whether the HIS component has been sustained; indicators 1-C (OR studies completed) and 1-D (data used to make decisions) indicate whether the OR component has been sustained; indicator 4-B (continuing health education policy implemented) indicates whether the health education component has been sustained, and indicators 4-A, D, E, and F indicate whether the training component has been sustained.

The findings of these indicators for the EPI, CDD, and malaria components in Guinea and Rwanda are summarized in Table 3. These data indicate that HIS was sustained in both countries (although apparently not used effectively in CDD and malaria in Rwanda); that OR and health education were sustained in EPI in both countries but not in CDD or malaria, and that training was sustained but not integrated with the MOH training program in both countries.

This evidence supports the conclusion from Section III. A. that the CCCD programs have, in fact, been at least partially sustained. Further, these objective indications of the degree to which support components have been sustained, in fact, do not correlate very well with the overall estimates of sustainability for the support components (as shown in Table 3 and Appendix B). Thus, the data also support the conclusion that the Sustainability Strategy is not adequate for support components and needs revision.

TABLE 3: Were Support Components Sustained in Guinea and Rwanda?

Support Component	Indicators from Sustain. Tables	Guinea				Rwanda			
		EPI	CDD	Mal	Overall Score	EPI	CDD	Mal	Overall Score
TRAINING	4-A. Training strategy implemented	+	+	+	2	+	+	+	3
	4-D. Needs assessment done	+	--	--		+	?	--	
	4-E. Trainers trained	+	+	+		+	+	+	
	4-F. Training integrated in MOH	--	--	--		--	--	--	
HE	4-B. HE policy implemented	+	--	--	1	+	?	--	2
HIS	1-B. HIS implemented	+	+	+	1	+	+	+	1
	1-D. Use data for decisions	+	+	+		+	--	--	
OR	1-C. OR studies done	+	--	--	0	+	+	+	0
	1-D. Use data for decisions	+	+	+		+	--	--	

Source: Sustainability Tables for Guinea and Rwanda (Appendix B).

C. Availability of Data

The CCCD Sustainability Strategy suggests numerous indicators that can be used to assess the extent to which projects have the five sustainability criteria. However, these indicators are useful measures only if good data can be found. The Nigeria assessment specifically addressed this issue.

The results were positive. There were adequate data in Nigeria to assess all of the indicators. Although the other three country assessments did not address the data availability issue as explicitly as Nigeria, there is no evidence that they encountered any problems in

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apparently found data to assess almost all of the indicators, as evidenced by the Sustainability Tables. Therefore, this four-country study supports the sustainability with respect to data availability.

The data that are available reflect conditions that are more or less concurrent in time with the assessment. The issue of data availability about past conditions was not addressed. This could be relevant to verification studies such as were performed by the Lesotho assessment where, ideally, the criteria indicators should be measured at the time that USAID funding terminates and not three years later.

D. Modifying the Criteria and Indicators

1. Adding "Ownership" as a Criterion

Three of the assessments, Guinea, Nigeria, and Rwanda, adopted "ownership" as a sixth criteria that is necessary for the sustainability of projects. The indicators of ownership can be seen in the Sustainability Tables in Appendix B.

Although there is not empirical evidence that ownership actually predicts project sustainability as there is for the other five criteria, the Nigerian assessment makes a strong argument for including it, which is paraphrased here:

> In Nigeria, ownership is not a natural consequence of the constituency building and negotiation process. Years of dependence on donors have made it easy for Nigerians to accept projects which are pivotal but over which they have no control. These "donor projects" are seen as external, not owned by Nigeria. Even when they deliver key services and are perceived to be helping the people, such external "donor" projects manifest a lack of involvement and generally *laissez faire* attitude among workers at every level as well as permissive attitudes about wastefulness and fraud in the use of project resources. The assessment team observed numerous examples of such projects that appeared to be unsustainable because they were not Nigerian.
>
> This is not the case in projects that Nigeria sees as its own. Local projects have been demonstrated time and again to be well run, with scrupulous attention to handling of resources and delivery of services that have been paid for. The key seems to be financial contributions by Nigerians at all levels. All of the approximately 100 Nigerian respondents asked about this agreed that financial contributions by Nigerians at all levels was a necessary ingredient -- total unanimity of opinion. (pages 4-19 and 5-3, Nigeria CCCD Sustainability Assessment)

The Guinea report offers the example of the reluctance of USAID missions to accept ownership of centrally funded projects as a case in point.

Although ownership may be necessary for sustainability, it did not serve to differentiate between the sustainability of different components. From the Sustainability Tables, it can be seen that in Guinea and Nigeria, ownership was positive or not recorded for all the components, thus providing no differentiation whatsoever. In Rwanda, ownership provided a slight degree of differentiation among the components.

2. Adding "Affordability" as a Criterion

One country assessment, Lesotho, argues that affordability and perceived affordability is a necessary attribute for sustainability and should be added to the Sustainability Strategy as an objective. It parallels perceived effectiveness. The Lesotho assessment report summarizes the recommended objective as follows:

> If project activities and benefits are perceived by the government, especially the Ministry of Health and the Ministry of Finance, as affordable, then it is more likely that these activities and benefits will be sustained when donor funding stops.

The key point made by the Lesotho report is that when governments allocate budgets among competing health programs, the affordability of the program is a key criteria, possibly more important than perceived effectiveness.

3. Adding Indicators

The Guinea and Rwanda assessments added "public perception" as an indicator of the perceived effectiveness criteria and "procedure for ending CCCD Project assistance" as an indicator of the respectful negotiation criteria. The Nigeria assessment developed the first four indicators of the ownership criteria, and the Guinea and Rwanda assessments added "perception of project need at all levels." (See Appendix B.)

4. In Search of Empirical Evidence to Support Added Criteria

The two new project related criteria, ownership and affordability, have been argued persuasively but not tested empirically. It may be worthwhile to analyze these proposed criteria against the data in the earlier CDIE six-country study. That study looked at a large number of project attributes, some of which were found not to be significantly related to sustainability. Further, the original study combined various attributes into broader groupings, the details of which may contain evidence in support of or against the newly proposed criteria.

A similar analysis might be made of the effect of donor support in the earlier data. Its strong role in these four assessments suggests it is worth exploring further.

In light of the powerful effect of contextual factors, a similar recourse might be made to the earlier data in order to address contextual factors in the Sustainability Strategy. It may well be that different project attributes are called for (in order to maximize sustainability) in negative contextual conditions than in positive ones.

E. The Issue of Other Donor Support

The definition of sustainability adopted by the four CCCD country sustainability assessments and by the CCCD Sustainability Strategy is the same one used in the CDIE/USAID study which identified the important sustainability attributes. The CDIE study uses three years following the cessation of USAID funding as the definition of sustainability. It does not address whether a project is sustained or not if it continues to receive funding from other donors.

This is a particularly important issue in Africa where family, community, and government resources are very small relative to the needs and are likely to remain so for quite a while, and where many donors have been making and continue to make substantial contributions. It may be that in Africa, one of the most successful sustainability strategies is to "market" programs to a sequence of donors until the program has built sufficient effectiveness, efficiency, and community and political support to successfully compete for required resources within the country.

The Lesotho assessment addresses this issue explicitly because a large proportion of Lesotho's health budget is donor supported. The continuation of most CCCD activities and benefits is in part due to these resources. The assessment argues that, in the case of Lesotho, it would not be sensible to use a definition that excluded all the donor-supported projects from the realm of sustainability.

In fact, as noted above, the main programs and CCCD activities in all four countries continued to receive significant financial support from other donors following the termination of USAID funding. In Guinea, the components in EPI, CDD, malaria, training, and HE received support from many donors including WHO, UNICEF, World Bank, and NGOs; in Rwanda, the EPI, CDD, and training components received support from WHO, UNICEF, and World Bank; Lesotho receives over 50 percent of its health budget from other donors and, according to the assessment report, had the third highest foreign aid per capita among LDCs in 1988 (although this may change drastically in the future due to the changes in South Africa); and as Africa's most populous country, Nigeria also receives very substantial support from other donors.

If this is a realistic option for some African projects, then it may be important to recognize it explicitly in the design phase of projects as it may lead to different operational strategies than other options for achieving sustainability, such as an early shift to cost recovery.

F. Is the Concept of Sustainability Misguided?

The Lesotho report argues that the concept of sustainability is fundamentally flawed and should be replaced, that it is a confusing mix of two elements:

1. It includes cost-benefit considerations, where the real issue is whether the investment of resources in a project is worth the future stream of benefits from the project, and

2. It includes intentions to change the fundamental way in which health sector institutions perform in relation to health care.

The Lesotho report argues that a cost-benefit framework is more appropriate. It does not really matter whether or not benefits from a CCCD Project continue for three years or any other number of years into the future. Some projects may achieve such high payoffs during the period of project funding that future benefits are not required to justify the original investment. Thus, the arbitrary selection of "three years" is not necessary. Projects should not be started unless there is appropriate evidence that the value of project benefits will provide an acceptable rate of return for the project's resources.

Sustainability may include intentions to institutionalize different ways of doing things or thinking about things in the host country. This amounts to an attempt to change its health subculture, e.g., change priorities, change intellectual styles, change values. The Lesotho report argues that such changes, while not necessarily wrong, should not be confused with success in a cost-benefit sense, should certainly be made quite explicit in the beginning, should not be swept under the cover of sustainability, and, in any case, are unlikely changes to achieve, at least in the time frame of most USAID projects. Thus, the Lesotho report recommends replacing the word "sustainability" with more explicit descriptions of the issues in question. Be explicit, the report suggests, about the fundamental changes in the health system that are implicit in the sustainability paradigm.

IV. CONCLUSIONS AND LESSONS LEARNED

The major findings of the individual assessments and of this summary report are presented throughout this report. In this section, we summarize the major conclusions and lessons that emerged from the analysis of all four assessments, and list the lessons from the individual reports.

A. Major Conclusions in Summary Report

1. African health projects can be sustained. The ACSI-CCCD Projects attest to this. Furthermore, health projects can be sustained in the face of negative economic and political conditions, even though their continuation is likely to be fragile due to such conditions.

2. Sustainability is multi-dimensional, in the sense that several factors contribute to the sustainability of project activities and benefits, including the five criteria. This conclusion directly counters views holding that sustainability is solely or primarily the result of cost reimbursement schemes or other one-dimensional solutions.

3. In Africa, continuing financial support from other donors appears to be a successful strategy for sustaining project activities and benefits. USAID may want to encourage this strategy in conjunction with other financial support strategies.

4. The strategy of supporting existing PHC programs appeared to be one of the keys to sustainability of direct components.

5. The sustainability criteria should be incorporated as part of the original objectives of projects and in project work plans. The phase-out process and strategies for sustaining project activities and benefits should be addressed by all parties from the beginning.

6. The assessment methodology proposed in the ACSI-CCCD Sustainability Strategy is generally doable and useful, and can be applied in many African health projects. Important advantages of that methodology include:

   a. The five criteria and associated indicators are appropriate for direct service components.

   b. Data on the indicators are likely to be available.

7. However, some improvements can be made in the Sustainability Strategy. These include:

   a. New criteria and indicators should be designed for the support components. The data in the original CDIE six-country study should be used in this effort.

b. Both "ownership" and "affordability" should be seriously evaluated for inclusion in the set of sustainability criteria. The data in the original CDIE six-country study should be used in this effort.

c. The methodology used by the Lesotho assessment, which measured the extent to which activities and benefits were actually sustained in comparison to the predicted sustainability based on the criteria and indicators, should be formalized and included in the strategy.

8. Support components were not sustained as well as direct service components, possibly because they were started more recently, and did not enjoy a strong existing base nor financial support from other donors.

B. From the Guinea Report

1. Political will and commitment from the highest levels of government are necessary for sustainability. Such commitment must be proclaimed by authorities and felt by the public.

2. Management skills specific to the job assignment are important for sustainability, both in the project and in the USAID mission. Inexperienced managers in the project or in the USAID mission can seriously decrease the prospects for sustainability. A related lesson is that USAID missions without public health expertise are less likely to give the same priority to the sustainability of their health projects as their other projects.

3. Sustainability must be addressed at the conception and throughout a project by all concerned.

4. The development of support systems must keep pace with the development of direct service components.

5. Specific individuals rarely take personal responsibility for project sustainability.

6. Program managers often see new activities or proposed changes in terms of what effect it has on their power base rather than its effect on the public interest.

7. Regional or global objectives, such as vaccination targets, may be unrealistic in some countries. Failure to achieve these objectives should be viewed for what they are, unrealistic goals, and not a program failure.

8. Activities that function well always seem to be managed by strong, capable leaders.

9. Decentralization improves the delivery of services, and their efficiency.

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10. Failure to involve communities hinders sustainability.

11. Integration of project components into a viable national PHC program supports sustainability.

12. Support services require the same priority, time frame, and dynamism to succeed as direct service components. Generally they do not have these attributes to the same degree as direct service components.

13. The phasing out of a project is difficult and important, possibly more important to sustainability than what goes on during the project.

C. From the Nigeria Report

1. Responsibility for achieving project success must be assigned to particular individuals right from the start.

2. Projects that depend on one or too few key technical people are less likely to sustain because these key people often leave. A critical mass of key technical people is needed.

3. Projects that depend on a heavy inflow of external capital are unlikely to sustain. The example of the rise, and then the fall, of vaccination coverage in Nigeria as a result of the infusion of short-term donor funding is cited as a case in point.

4. Donor-supported projects should actively foster, and carefully avoid obstructing, local initiatives. "Bottoms up" planning with local communities helps. Examples of local initiatives thwarted by well-intended donor projects are cited.

5. In Nigeria, people who do not pay toward something do not feel any ownership for it, even if they have been involved from the start. Thus, the sense of ownership is intimately linked to financial inputs.

6. Training programs are an effective way to communicate information that enhances project credibility and sense of ownership. There is evidence that this has increased budget allocations at the state level.

7. Unstable leadership in projects seriously diminishes the chances for sustainability.

8. Technical assistance should always have the objective of building local capability in order to achieve sustainability.

D. From the Rwanda Report

1. The private health sector, which is demanding but well equipped and rewarding, is attractive to many public sector health professionals.

2. The extensive cooperation between the private and public sectors has maximized the sustainability of CCCD activities.

3. Top priority programs such as EPI perform better at all levels, but particularly at secondary peripheral levels. The status associated with high priority from the central level confers priority at the periphery.

4. Health personnel motivation is essential to project success and sustainability, including motivation due to per diem payments. Elimination of such incentives can reduce sustainability.

5. Personnel skills are not sufficient to sustain activities. Support resources are also needed. Problems in sustaining the malaria control program due to lack of educational materials is a case in point.

E. From the Lesotho Report

Although the Lesotho report did not contain a specific section on lessons learned, the following lessons were implicit in the findings reported in the Executive Summary.

1. User charging schemes can be feasible, if the fee is substantial, and can significantly strengthen sustainability.

2. Affordability is central to any analysis of health benefits in Lesotho, and therefore to sustainability.

3. Outflow of skilled workers to other sectors or other countries is a serious impediment to sustainability.

4. Health education is key to sustainability of PHC projects.

5. Continuing training of health personnel and their awareness is another key to sustainability of PHC projects.

6. Community health worker programs can be the key to delivery of PHC services.

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APPENDIX A

Project-Related Sustainability Criteria

PROJECT-RELATED SUSTAINABILITY CRITERIA[11]

1. Perceived Effectiveness. Project effectiveness and perceived project effectiveness tend to go together. In the CDIE six-country study, the reputation for effectiveness was usually backed by objective evidence, but it was the reputation for effectiveness that was important for sustainability. The reputation influenced the decisions of health officials, providers, and beneficiaries irrespective of scientific evidence. Nevertheless, the most ineffective projects were the least sustainable. The most sustainable projects were all perceived as effective during the life of the project.

2. Integration. The CDIE study found that projects designed and implemented as vertically-run separate hierarchies were less sustained than projects that were integrated into the existing institutional hierarchies.

3. Financing. Two primary sources of host country funds to maintain project activities are government budgets (at all levels of government) and payments from beneficiaries. The CDIE study found that often, but not always, project sustainability is dependent in part on whether one or both of these funding sources were developed during the project.

4. Training. The CDIE study found that projects with strong training components tended to be sustained and those without training tended not to be sustained.

5. Respectful Negotiation. The CDIE study found that projects that were viewed by national officials as imposed by USAID were less likely to be sustained than projects that were designed and approved in a mutually respectful negotiating process involving give-and-take between USAID and the government. Further, the study found that African countries were the least able to resist the imposition of projects by USAID.

[11] Source: CDIE/USAID, 1990, *op.cit.*

APPENDIX B

Sustainability Tables

Sustainability Table
Nigeria

Criteria	EPI	CDD	Mal	Train	HE	HIS	OR	M&E
1	+	--	+	+	+/--	+	+	+
2	?	+	--	+	--	+/--	+	?
3	+/--	+	+/--	?	--	--	--	--
4	?	--	--	+	?	?	?	--
5	?	?	?	?	?	?	?	?
6	+	+	?	+	?	+	+	?

NOTES: (1) Favorable (+), unfavorable (--) or unstated (?) influence of criteria on sustainability of project components. Unstated influence is likely to be insignificant influence. "+/--" refers to criteria with some indicators positive and some negative. (2) Summarized from Table 5 in the Nigeria Sustainability Report. Data on all indicators not available. (3) The project criteria in column 1 are:

1 - Perceived effectiveness
2 - Integration
3 - Financing
4 - Training
5 - Respectful negotiation
6 - Ownership

GUINEA

PROJECT RELATED CRITERIA AFFECTING SUSTAINABILITY AND THEIR INDICATORS

1. **Perceived Effectiveness**
   - A. Development of workplans and policy statements at national, district, and local levels.
   - B. Implementation of HMIS or special surveys to measure project impact.
   - C. Completion of operations research and special studies to assess program quality and develop solutions.
   - D. Use of data to make decisions, identify problems, develop solutions, and to confirm project's importance at health sector community meetings.
   - E. Adequate staffing and resources at the service delivery level.
   - *F. Public perception of project effectiveness.
2. **Integration and Institution Strengthening**
   - A. Effective supervisory system (using checklists) which decentralizes technical and managerial responsibility to the peripheral level.
   - B. Integration of service delivery at delivery sites.
   - C. Integration at national level into existing MOH structures.
   - D. Support activities operational and integrated at national level.
   - E. Competency-based assessments of worker performance.
   - F. Reliance on host country technical expertise
3. **Local Financing, Community Participation, and Private Sector Provision of Services**
   - A. Assumption of project costs by government.
   - B. Implementation of fee-for-service/cost recovery.
   - C. Private provision of project services.
   - D. Donor complimentarity and coordination.
4. **Strong Training Component**
   - A. Training strategy developed and implemented.
   - B. Continuing health education policy developed and implemented.
   - C. Implementation of supervisory system.
   - D. Completion of facility training needs assessments.
   - E. Trainers trained in how to train.
   - F. Project training activities integrated into existing MOH training structures.
5. **Constituency Building Through a Process of Mutually Respectful Negotiation**
   - A. Nationals participate in country assessment, project development, and project modification and clearly view the project as a priority.
   - B. Partners participate in project workshops.
   - C. MOH procedures facilitate the inclusion of local concerns and decisions within national level plans.
   - *D. Procedure for ending CCCD Project assistance.
6. **Ownership**
   - *A. Perception of project need at all levels.
   - B. Perception of project ownership at all levels.
   - C. Project-related decisions are made by organizations/bodies which represent local constituencies.
   - D. Project development and modifications originate with nationals.
   - E. Continuously increasing assumption of the project (costs, management, etc.) by community members who are the beneficiaries.

*Added by the Guinea team.

Favorable (+) or unfavorable (-) status of indicators for sustainability of project services and support systems.

Criteria	EPI	CDD	Malaria	Training	H. ED	HMIS	Op. Res.
1							
A	+	+	+	-	-	+	*
B	+	+	+	+	-	+	*
C	+	-	-	-	+	-	*
D	+	+	+	+	+	+	*
E	+	-	+	+	-	+	*
F	+	+	+	-	+	NA	*
2							
A	+	+	+	+	-	-	*
B	+	+	+	NA	+	+	*
C	+	+	+	+	+	+	*
D	+	+	+	-	-	+	*
E	-	-	-	-	-	-	*
F	+	+	+	+	-	-	*
3							
A	-	-	-	+	-	+	*
B	+	+	+	-	-	-	*
C	+	-	+	-	N/A	-	*
D	+	+	+	+	+	+	*
4							
A	+	+	+	+	-	+	*
B	+	-	-	-	-	-	*
C	+	+	+	+	-	-	*
D	+	-	-	-	-	-	*
E	+	+	+	+	+	+	*
F	-	-	-	-	-	-	*
5							
A	+	+	+	+	+	+	*
B	+	+	-	+	+	+	*
C	+	+	+	+	+	+	*
D	-	-	-	-	-	-	*
6							
A	+	+	+	+	+	+	*
B	+	+	+	+	+	+	*
C	+	+	+	+	+	NA	*
D	+	+	+	+	+	+	*
E	+	+	+	+	+	+	*
SCORE	3	2	2	2	1	1	0

Score:
0 = Not sustainable, 1 = Permanent activity but decline in quality, 2 = Permanent activity and maintenance of quality, 3 = Permanent activity with improved quality, NA = Non Applicable, * = Not yet developed

CCCD/RWANDA

PROJECT RELATED CRITERIA AFFECTING SUSTAINABILITY AND THEIR INDICATORS

1. **Perceived Effectiveness**
   - A. Development of workplans and policy statements at national, district, and local levels.
   - B. Implementation of HMIS or special surveys to measure project impact.
   - C. Completion of operations research and special studies to assess program quality and develop solutions.
   - D. Use of data to make decisions, identify problems, develop solutions, and to confirm project's importance at health sector community meetings.
   - E. Adequate staffing and resources at the service delivery level.
   - *F. Public perception of project effectiveness.
2. **Integration and Institution Strengthening**
   - A. Effective supervisory system (using checklists) which decentralizes technical and managerial responsibility to the peripheral level.
   - B. Integration of service delivery at delivery sites.
   - C. Integration at national level into existing MOH structures.
   - D. Support activities operational and integrated at national level.
   - E. Competency-based assessments of worker performance.
   - F. Reliance on host country technical expertise
3. **Local Financing, Community Participation, and Private Sector Provision of Services**
   - A. Assumption of project costs by government.
   - B. Implementation of fee-for-service/cost recovery.
   - C. Private provision of project services.
   - D. Donor complimentarity and coordination.
4. **Strong Training Component**
   - A. Training strategy developed and implemented.
   - B. Continuing health education policy developed and implemented.
   - C. Implementation of supervisory system.
   - D. Completion of facility training needs assessments.
   - E. Trainers trained in how to train.
   - F. Project training activities integrated into existing MOH training structures.
5. **Constituency Building Through a Process of Mutually Respectful Negotiation**
   - A. Nationals participate in country assessment, project development, and project modification and clearly view the project as a priority.
   - B. Partners participate in project workshops.
   - C. MOH procedures facilitate the inclusion of local concerns and decisions within national level plans.
   - *D. Procedure for ending CCCD Project assistance.
6. **Ownership**
   - *A. Perception of project need at all levels.
   - B. Perception of project ownership at all levels.
   - C. Project-related decisions are made by organizations/bodies which represent local constituencies.
   - D. Project development and modifications originate with nationals.
   - E. Continuously increasing assumption of the project (costs, management, etc.) by community members who are the beneficiaries.

*Added by the Guinea team.

Favorable (+) or un-favorable (-) status of indicators for sustainability of project services and support systems.

Criteria	EPI	CDD	Malaria	Training	H. ED	HMIS	Op. Res.
1							
A	+	+	+	+	+	+	+
B	+	+	+	+	+	+	-
C	+	+	+	-	-	+	-
D	+	-	-	+	+	+	+
E	-	+	-	-	+	-	NA
F	+	+	?	NA	+	NA	NA
2							
A	+	+	+	+	-	+	-
B	+	+	+	NA	+	+	NA
C	+	+	+	+	+	+	+
D	+	+	+	-	+	-	-
E	+	-	-	+	-	-	-
F	+	+	+	+	+	-	-
3							
A	-	-	-	-	-	-	-
B	-	+	+	-	-	-	NA
C	+	+	+	+	+	+	-
D	+	+	+	+	+	+	-
4							
A	+	+	+	+	+	+	-
B	+	+	-	+	+	+	-
C	+	+	+	+	-	-	-
D	+	+	-	+	-	-	-
E	+	+	+	+	+	+	-
F	-	-	-	-	-	-	-
5							
A	+	+	+	+	+	+	-
B	+	+	+	+	+	+	+
C	+	+	+	+	+	-	+
D	-	-	-	-	-	-	-
6							
A	+	+	+	+	+	+	-
B	+	+	+	+	+	+	+
C	-	-	-	-	-	NA	-
D	+	+	+	+	+	+	+
E	-	+	+	+	-	-	-
SCORE	3	2	1	3	2	1	0

Score:
0 = Not sustainable, 1 = Permanent activity but decline in quality, 2 = Permanent activity and maintenance of quality, 3 = Permanent activity with improved quality, NA = Non Applicable, * = Not yet developed

[illegible] Sus[illegible]

CCCD/LESOTHO

PROJECT RELATED CRITERIA AFFECTING SUSTAINABILITY AND THEIR INDICATORS

1. **Perceived Effectiveness**
   - A. Development of workplans and policy statements at national, district, and local levels.
   - B. Implementation of HMIS or special surveys to measure project impact.
   - C. Completion of operations research and special studies to assess program quality and develop solutions.
   - D. Use of data to make decisions, identify problems, develop solutions & to confirm project's importance at health sector community meetings.
   - E. Adequate staffing and resources at the service delivery level.

2. **Integration and Institution Strengthening**
   - A. Effective supervisory system (using checklists) which decentralizes technical and managerial responsibility to the peripheral level.
   - B. Integration of service delivery at delivery sites.
   - C. Integration at national level into existing MOH structures
   - D. Support activities operational and integrated at national level

3. **Local Financing, Community Participation and Private Sector Provision of Services**
   - A. Assumption of project costs by government.
   - B. Implementation of fee-for-service/cost recovery.
   - C. Private provision of project services.

4. **Strong Training Component**
   - A. Training Strategy developed and implemented.
   - B. Continuing health education policy developed and implemented.
   - C. Implementation of supervisory system.
   - D. Completion of facility training needs assessments.
   - E. Trainers trained in how to train.
   - F. Project training activities integrated into existing MOH training structures.

5. **Constituency Building Through a Process of Mutually Respectful Negotiation**
   - A. Nationals participate in country assessment, project development, and project modification and clearly view the project as a priority.
   - B. Partners participate in project workshops.
   - C. MOH procedures facilitate the inclusion of local concerns and decisions within national level plans.

Criteria	EPI	CDD	ARI	Training	H. ED	HMIS	Op. Res.
1							
A	+	+	+	+	+	+	-
B	+	+	+	-	-	NA	NA
C	-	-	-	-	-	-	NA
D	+	-	-	-	-	-	NA
E	-	-	-	-	-	-	NA
2							
A	-	-	-	-	-	-	NA
B	+	+	+	+	+	+	NA
C	+	+	+	+	+	+	NA
D	-	-	-	NA	NA	NA	NA
3							
A	-	-	-	-	-	-	-
B	-	-	-	-	-	-	-
C	-	-	-	-	-	-	-
4							
A	+	+	+	+	-	+	-
B	-	-	-	NA	-	NA	NA
C	-	-	-	+	-	-	NA
D	-	-	-	+	-	-	NA
E	+	+	+	+	-	?	-
F	NA	NA	NA	+	NA	NA	NA
5							
A	+	+	+	+	+	+	NA
B	+	+	+	+	+	+	NA
C	+	+	+	+	+	+	NA

Favorable (+), un-favorable (-), or not applicable (NA) status of indicators for sustainability of project services and support systems.